FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Thank you for choosing the YMCA of Greater Cleveland as your child care provider! We look forward to working with you and your child. Below are a few important reminders to ensure that we have the information we need.

1. Please fill out and complete all forms in this packet and submit to the payment registrar office no later than one week prior to your child's first day in the program. **Payment Registrar's Office**: childcarereg@clevelandy.org or Fax: 216-479-0135

2. Please be sure to fill out and sign all forms in the packet so as not to delay your child's enrollment in the program.

3. We require two local contacts residing at different addresses under the Emergency Contact section.

4. The Child Medical/Physical Care Plan form only needs to be filled out if you answered YES to any of the specific questions on page two of the enrollment form.

5. There is an "ODJFS Request for Administration of Medication" form that is required for the use of hand sanitizer on your child. Please do not change the words that are currently entered. If your child will be bringing any other medication to the program (including inhalers or Epi-pens) then you will need to complete another Request for Administration of Medication form which can be found on our website.

6. The YMCA does not accept enrollment for a child whose parent or guardian refuses to sign the Permission to Transport section of the Child Enrollment form.

7. Your child's program may participate in the Child and Adult Care Food Program (CACFP), a federal program that provides reimbursement to child care centers for the meals we provide. You must complete the income eligibility application in order for your child to participate in the YMCA program. If your income is above the listed eligibility guidelines, you only need to list your child (ren) name and sign and date the form. Please contact the Area Youth Development Director if you have any questions.

8. Our Parent handbook along with other information/forms/newsletters is available online. Go to http://www.clevelandymca.org then select your YMCA location for this specific information.

YMCA OF GREATER CLEVELAND
1801 Superior Avenue Suite 130
Cleveland, Ohio 44114
P 216-263-6860
www.CLEVELANDYMCA.org

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home
Home Address			City
State	Zip Code	Home Telephone Number	

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**_Do Not Give Permission_ to Transport**	
Program or Home Name		**OR**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken: Not Applicable	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time
	Aug. 2017 - May 2018

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☑ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage
Hand Sanitizer	A Squirt Full

To be administered at the following times	For the following period of time
When Soap and Water are not readily available	Aug. 2017 - May 2018

☑ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Family Information (School Age)

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Child's Last Name	Child's First Name	Nickname (if any)

By providing complete information about your child, you will be assisting the staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff who care for your child.

Members of child's immediate family

Who lives at home with your child?

Language(s) spoken in your home/Primary Language

Changes or transitions that your child recently experienced or is experiencing? (ie. New home, birth of sibling, divorce, school issues, death of family member, friend, pet)

Any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, language, etc)

Foods/Meals

Favorite Foods

Foods that are disliked

Are there any foods your child should not be fed? (Child Care Licensing requires a form to be completed for children with food allergies or dietary restrictions)

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

How do you reward your child's good behavior or accomplishments?

Is your child taking any lessons or participating in organized clubs/teams? (ie. Swim, dance, piano. Scouts, Youth Group, sports, etc)

What are some of your child's interests?

□ Art/Crafts
□ Sports/Large Motor Activities
□ Electronics (Video Games, Computer, etc)
□ Science/Exploration/Nature
□ Nutrition/Physical Fitness
□ Music
□ Drama/Film
□ Writing/Literature/Reading
□ Math
□ Other: _____
□ Other: _____
□ Other: _____

Please check all of the words that best describe your child's personality and general behavior:

□ Active □Adventurous □ Affectionate □ Anxious □ Bossy □ Calm □ Cheerful
□ Content □ Creative □ Curious □ Emotional □ Energetic □ Excitable □ Friendly
□ Happy □ Insecure □ Likes Structure/Routine □ Loud □ Loving □ Outgoing □ Quiet
Prefers Adult Attention □ Sensitive □ Serious □ Stubborn □ Talkative

Please Rank from 1-10 (10 most important) the importance of School Age Activities:

Snack ___ Arts & Drama ___ Physical Activity ___ Structured Play ___ Friends ___
Rest ___ Homework ___ Free Play ___ Safe Environment ___ Learning Activities ___

What is your child's favorite subject (s) in school/what subject(s) is a challenge?

Favorite:

Challenge:

Is there anything that is making your child excited about starting in this program?

Is there anything that is making you or your child anxious about starting in this program?

What are your expectations of this program? What goals do you hope for your child to achieve in this program?

Any other information that would be helpful for the staff caring for your child to know?

Do you or anyone in your family have a hobby, skill, or area of expertise that you would be interested in sharing with school age youth?

Parent/Guardian Signature:	Date:

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
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2017-2018 YMCA of Greater Cleveland Child Care Permission Form

Waiver

I am an adult over 18 years of age and wish to participate in YMCA of Greater Cleveland (the "YMCA") membership/program activities, and wish my children or legal wards to participate and give them permission to participate in YMCA activities. As used in this Agreement "children" shall include legal wards and "parent" shall include legal guardian. As a condition to being permitted to utilize the facilities, services, and programs of the YMCA for any purpose, including but not limited to observation or use of the facilities or equipment, or participation in any off-site program affiliated with the YMCA, I, the undersigned, acknowledge, agree, and represent that I have inspected and carefully considered the facilities and programs. I understand that even when every reasonable precaution is taken, accidents can happen. As a condition to participation by me or my children in YMCA activities, on my behalf and on behalf of my children, I waive and release any claims for loss or injury incurred or suffered which I or my children might make against the YMCA, its sponsors, officers, employees, volunteers, or contractors as a result of participating in YMCA activities or using its facilities. I further agree to indemnify the YMCA against and hold it harmless from loss incurred as a result of claims against it based upon alleged actions or omissions by me or my children. I have read the authorization, waiver, and release, understand it, and am voluntarily signing it.

I acknowledge the membership waiver and being in sympathy with the Mission Statement of the YMCA of Greater Cleveland, hereby apply for a program membership for child care.

Parent/Guardian Signature: _____Date:_____

Photography Release

I give my permission to the YMCA of Greater Cleveland to use without limitation or obligation, photographs, film footage, or tape recordings which may include me or my children's image, voice, or name for the purpose of promotion of interpreting YMCA programs.

I hereby release and discharge the YMCA of Greater Cleveland, as well as the person/organization for who took the photographs, from any and all claims and demands arising out of or in connection with the use of the photos or video taping.

☐ No; I do not want my child to be photographed ☐ Yes; my child may be photographed for these purposes.

Parent/Guardian Signature: _____Date:_____

Authorization for Release

I hereby authorize the YMCA of Greater Cleveland to release my child, _____, to the following individuals. In addition, I understand that for safety purposes, photo identification will be requested for verification purposes.

Name: _____Relationship: _____ Phone#_____
Name: _____Relationship: _____ Phone#_____
Name: _____Relationship: _____ Phone#_____

Parent/Guardian Signature: _____Date:_____

Permission to Transport (Lakewood and West Park Programs Only)

I give the YMCA of Greater Cleveland permission to routinely transport my child, _____, to/from the YMCA child care program by the vehicle provided by the YMCA program for the 2016-2017 school years. Routine transportation is provided to/from a child's school to the designated YMCA program. This routine trip will not have access to water that is two or more feet in depth. All other trips will require a completed permission slip on file.

To: _____ From: _____
(Name of YMCA Program) (Name of School)
To: _____ From: _____
(Name of School) (Name of YMCA Program)

Parent/Guardian Signature: _____Date:_____

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YMCA Parent Statement of Understanding

- I have received the Parent Handbook and acknowledge that it is my responsibility to review the handbook and comply with the policies. If I have questions regarding a specific area of content in the handbook, a YMCA Staff member will clarify the area for me.

- I understand that no toys, personal electronic devices or money may be brought to the program.

- I understand that the YMCA of Greater Cleveland is not responsible for personal property lost, damaged or stolen while members and / or program participants are using YMCA facilities, on YMCA premises, or involved in YMCA programs.

- I understand that it is my responsibility to sign my child in upon arrival in the morning and sign my child out before leaving the program in the afternoon, on the appropriate form made available by the YMCA staff.

- I understand that my child may not be released to anyone without prior written documentation and presentation of valid photo identification.

- I understand the balance of weekly tuition is due in accordance with YMCA payment policies. Any payment received past the stated deadline will be charged a $25 late fee. This fee will be automatically drafted from the same account from which I pay my tuition.

- I understand no credits, refunds or adjustments in fees will be made for absences due to, illness, vacation, behavioral incidents or other incidental reasons.

- I understand that if I choose to withdraw my child entirely from any child care program I must submit in writing a withdrawal letter to the Payment Registrar Office at least two weeks in advance of the last day of attendance. I understand that by doing so my child will no longer be considered enrolled in the program and if care is needed at a later date and there is a wait list for the program, my child will be added to the bottom of the list.

- I understand a refund will not be given if a two weeks' notice was not sent to the Payment Registrar Office requesting withdrawal from a child care program.

- I understand that the Staff Code of Conduct prohibits YMCA staff from meeting outside the YMCA with children they have met in YMCA programs. This includes, but not limited to: baby-sitting, sleepovers and inviting children into their home. YMCA staff may not transport program children in their personal vehicles.

Parent/Guardian Signature: _____Date:_____

YMCA OF GREATER CLEVELAND
1801 Superior Avenue Suite 130
Cleveland, Ohio 44114
P 216-263-6860
www.CLEVELANDYMCA.org

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS Fiscal Year 2017 – 2018

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an a*dult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME _____

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT LIST SWIPE CARD NUMBER. 600… numbers not valid.

Check type of benefit: □ FOOD ASSISTANCE (SNAP) or □ OHIO WORKS FIRST (OWF)

1. CASE NO.	__ __ __ __ __ __ __ __ __ __ __ __
2. CASE NO.	__ __ __ __ __ __ __ __ __ __ __ __
3. CASE NO.	__ __ __ __ __ __ __ __ __ __ __ __
4. CASE NO.	__ __ __ __ __ __ __ __ __ __ __ __

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ 200 / weekly	$ 150 / twice month	$ 100 / monthly	$ _____/_____
1.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
6.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____ **SIGNATURE OF ADULT HOUSEHOLD MEMBER**	* _____ **DATE**	*** If Part 3 is completed, insert last 4 digits of Social Security Number** ☐☐☐☐ **(Check if applicable) I do not have a Social Security Number** ☐
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

State Distribution: 7/6/2017

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on □ Food Assistance/OWF Case No.
□ Household Size & Income
□ Foster Child

☐ **REDUCED**, based on Household Size & Income

Total Household Size: _____

Total Household Income: $_____
Per: □ Week □ Every 2 Weeks □ Twice Per Month □ Month □ Year

☐ **PAID,** based on □ Income Too High
□ Incomplete
□ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date	Expiration Date
		(From the first of month of date signed)	(Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the United States Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits**.** An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 10 or 12-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the money was received.

1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date the form.

c) * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA either by mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights,1400 Independence Avenue, S.W.,Washington, D.C. 20250-9410, by fax (202) 690-7442, or email to program.intake@usda.gov. USDA is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES – 185%
Guidelines to be effective from July 1, 2017 through June 30, 2018
Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	22,311	1,860	930	859	430
2	30,044	2,504	1,252	1,156	578
3	37,777	3,149	1,575	1,453	727
4	45,510	3,793	1,897	1,751	876
5	53,243	4,437	2,219	2,048	1,024
6	60,976	5,082	2,541	2,346	1,173
7	68,709	5,726	2,863	2,643	1,322
8	76,442	6,371	3,186	2,941	1,471
For each additional family member, add	7,733	645	323	298	149